GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST TO CHANGE INFORMATION ON A PREVIOUSLY FILED FORM WC-14

Instructions: The purpose of this form is to change mistakes concerning certain information (Employee Name, Social Security Number, Date of Injury, or County of Injury) on a previously filed Form WC-14. If you want to change mistakes with information previously furnished on a Form WC-14, then indicate the change on this form and file it with the Board. Complete a new Form WC-14 to add or change any information pertaining to the employer, insurer, servicing agent, part of body injured, to add date of injury, hearing issue, or mediation issue. This form shall not be used to change an address of record, add additional parties, or additional dates of injury.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

A. CHANGED INFORMATION

The information provided on the Form WC-14 dated _____ is amended as follows:

	Change From	Change To
❑ Employee Name		
❑ Social Security Number		
❑ Date of Injury		
❑ County of Injury		
Reasons:		

B. CERTIFICATION

❑ I certify that I have today sent a copy of this form to all parties in this claim and to the State Board of Workers' Compensation, 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299

Print name here	Address		
Signature	City	State	Zip Code
E-mail			GA Bar number
Phone Number	Date		

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).